DOCUMENT RESUME

ED 247 503 CG 017 665

AUTHOR Sauer, G. C., Jr.; And Others
TITLE Planning for the Vocational Implications of Head Trauma.
SPONS AGENCY Texas Tech Univ., Lubbock.
PUB DATE Apr 84
NOTE 23p.; Paper presented at the Annual Convention of the Southwestern Psychological Association (30th, New Orleans, LA, April 19-21, 1984).
PUB TYPE Reports - Research/Technical (143) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Career Counseling; Case Studies; *Counselor Role; Interest Inventories; Patients; *Vocational Evaluation; *Vocational Interests; *Vocational Rehabilitation
IDENTIFIERS Adjective Checklist (Gough and Heilbrun); *Head Injuries; Neuropsychology; Problem Checklist; Self Directed Search

ABSTRACT

A model using career interest test results and career specific information to formulate vocational recommendations was tested on four head trauma patients who had been involved in car or motorcycle accidents at least 2 years before. As part of a psychological evaluation, patients completed the Self Directed Search (SDS), the Adjective Checklist (ACL), and the Problem Checklist (PCL). A structured interview was also conducted. Results showed that, overall, the Self Directed Search was foremost in offering several markers around which further recommendations and vocational explorations could focus. The PCL indicated problems only in a gross sense, underemphasizing attention, memory, and interpersonal and organizational problem areas. Too many items or scales hindered the utility of the ACL. The findings suggest the need for early vocational data collection and consistent follow-up procedures. By reviewing the SDS indices and assessing premorbid career adjustment, those at risk for nonreturn to work could be identified. At a later date the PCL and a brief interview could be administered if vocational adjustment problems appeared. (Case studies for the four patients are included.) (JAC)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED247503

Planning for the Vocational Implications of Head Trauma

G. C. Sauer, Jr.

Roger L. Greene

Stephen P. Farr

Texas Tech University

Paper presented at the Meeting of the Southwestern Psychological Association Convention, April, 1984, New Orleans.

This research was supported in part by a Graduate School Summer Research Award (1982) to the senior author.

CG 017665

U.S. DEPARTMENT OF EDUCATION
NATIONAL INSTITUTE OF EDUCATION
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

X This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official NIE position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

G.C. Sauer, Jr.

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

Planning for the Vocational Implications of Head Trauma

Neuropsychological assessment following head trauma is an increasingly important role of the psychologist (Filskov & Boll, 1981). Such assessments have shifted from a localization focus (Reitan, 1966) to a rehabilitation emphasis in which the neuropsychologist is called upon to make recommendations regarding a patient's ability to return to work (Golden, 1978). When neuropsychological deficits are severe and extensive, recommendations must focus on the possibility that pervious vocational endeavors are no longer possible. The vocational issue becomes one of what other vocations or jobs might be appropriate.

The neuropsychological literature typically approached rehabilitation in global terms (i.e., employable vs. unemployable) that are not conducive to making concrete recommendations about possibilities (Heaton & Pendleton, 1981). Some limited research has suggested that neuropsychological-specific measures have some potential for directing rehabilitation recommendations in terms of work readiness. For example, multiple regression procedures were used to identify 27 variables (e.g., Purdue Pegboard, WAIS digit span, etc.) that best indicated potential for ambulation and self-care rehabilitation (Ben-Yishay, Gerstman, Diller, & Haas, 1970). Also, Blyth (1981) has shown that mental problems such as noise intolerance and memory deficits are more critical than motoric

dysfunctions in predicting return to employment. Other neuropsychological research has focused specifically on the emotional implications of head trauma and concommitant effects on employment (Roberts, 1976). For example, Najenson, Groswasser, Mendelson, and Hackett (1980) suggest that a lack of motivation, self-control, and disability awareness show poor rehabilitation and vocational prognoses.

In contrast to the neuropsychology literature, vocational rehabilitation studies rely on work-related behavior assessment and career interest test results (e.g., Anchor, Sieveking, Peacock, & Pressley, 1979). Vocational evaluations typically take a hands-on approach to evaluating mostly unskilled and skilled work potential (e.g., McCarron & Ludlow, 1981). Consequently, there seems to be some potential in drawing from vocational evaluation approaches and incorporating those in neuropsychological assessments to allow greater specificity in neuropsychological vocational recommendations.

A plan is offered for the use of career interest test results and career-specific information to formulate vocational recommendations following head trauma. Case study examples are offered to exemplify the utility of such information in guiding neuropsychology vocational recommendation decision making.

Instruments

The Self-Directed Search (SDS; Holland, 1977) was used to assess career interests. The test is a 228 item, self-paced, self-scored appraisal of expressed career interests and self-estimated aptitudes. Scores for five domains (activities, competencies, occupations, and two sets of self-estimates) contribute to six summary scores that refer to expressed career interest areas: Realistic, Investigative, Artistic, Social, Enterprising, and Conventional. These global vocational orientations to the world of work comprise the points of the hexagonally depicted Holland typology (R, I, A, S, E, C). The highest three summary scores are used to represent a person's career interest Holland code (e.g., RIC for Realistic, Investigative, and Conventional career interests).

Completion of the test takes about 40 minutes. Corrected split-half realiability for the summary scores range from .83 to .95 (Holland, 1979). Test-retest reliability correlations range from .56 to .95 (Holland, 1979).

The SDS also offers measures of choice consistency and differentiation (Holland, Gottfredson, & Nafziger, 1975). Holland et al. have suggested the measures are "signs" of decision-making aptitude. Consistency is a measure of relationship between one's primary and secondary career interests on the Holland hexagon. Scores ranging from 1 (least consistent) to 3 (most consistent)

are assigned to opposite (1), alternate (2), or adjacent (3) hexagon positions. Differentiation is expressed as the absolute difference between one's highest and lowest summary scores. ~~Differentiation is expressed as the absolute difference between one's highest and lowest summary scores~~. By examining the SDS consistency and differentiation scores it was possible to consider the decision-making status of the patient.

The Adjective Checklist (ACL; Gough, 1980) is a 300 item adjective list. When scored the inventory provides 37 scales that describe emotional and personality features. In some studies (Rowell, 1967/1968; Scarr, 1966) the Adjective Checklist has been administered to a patient and a significant other to corroborate patient responses. Item alpha coefficients of reliability have a median correlation of .75. Test-retest item reliabilities have a median correlation of .65. Gough (1980) has identified six factors that comprise the inventory: Potency, Assertiveness, Sociability, Individuality, Dissatisfaction, and Constriction.

The Problem Check List (PCL; Oddy, 1982) was specifically developed for use with neuropsychology patients to ascertain emotional and somatic changes associated with head injuries. A specific form is available for administration to a significant other to corroborate head injured patients' results. Oddy and

Humphrey (1980) have found various relationships between items checked and posttrauma adjustment problems. For example, those indicating "difficulty in becoming interested in anything" engaged in fewer leisure activities. Reliability and/or validity data are not currently available.

In addition to the previous paper and pencil measures, a structured interview was developed to provide a comprehensive compilation of relevant vocational data. Information such as time off work following the trauma, to what job the patient returned, whether retraining took place, whether lateral job movements were made, and so on, were recorded.

Procedure

Patients were evaluated during a two to three hour session. When they arrived they were interviewed according to the structured interview so that pre-and posttrauma employment information could be obtained. Next, they completed the SDS. They stopped prior to the self-scoring section to reduce the usual 40 minute test time by half. Then they completed the ACL and PCL while a significant other concurrently completed the checklists. Neuropsychological evaluation data were available for all patients. All patient interviewing and career testing was completed by the first author.

The SDS was scored to derive the Holland-code-expressed career interests and differentiation/consistency measures. Holland (1979) has shown that multiple combinations of Holland codes should be explored for career possibilities. Particularly if there is less than an 8 point difference between SDS summary scores, it is likely other code combinations may lead to possible job interests. Consequently, jobs were recorded as possibilities for a patient based on their initial Holland code (e.g., RIC) and code combinations that were closely related (e.g., RCI or IRC). By listing jobs from the Dictionary of Holland Occupational Codes (Gottfredson, Holland, & Ogawa, 1982) that matched the patient's Holland code, it could be determined whether a patient's previous employment matched their current career interests. Then, planning for future employment could focus on their old job area or a closely similar job that still contained their career interests.

Structured interview employment data were coded according to the Dictionary of Occupational Titles (DOT; 1977). The DOT provides a numerical code for every U.S. job. The codes designate what the worker's relationship on the job is to "Data, People, and Things." The Data worker trait applies to working with numbers and figures. The People worker trait designates tasks dealing

with people and social processes. The Things worker trait applies to tasks involving objects and mechanical items. Within the Data, People, Things categories a numerical system designates graded degrees of involvement for each of the three traits. The higher the numerical designation the less the job demands of that particular worker trait. For example, the Data worker trait score of zero indicates "synthesizing" tasks. The People trait assigns a zero for "monitoring" and an eight for "taking instructions/ helping." Likewise, the Things trait ranges from a zero for "setting up" to a seven for "handling". By classifying each job according to its DOT code, the clients level of functioning within each of the Data, People, Things categories was determined. Then, any consequential changes between pretrauma employment to posttrauma employment could be examined within those categories.

The ACL was scored to provide standard scores for the 37 scales. Those scales outside one standard deviation from the mean were recorded. Using information from the ACL factor analysis (Gough, 1980), descriptors were used to best describe the individual and evaluate what descriptors might relate to vocational changes.

The PCL was scored and problem areas were listed. It was decided to cluster the items under general headings of somatic,

psychological, behavioral, memory, organizational, interpersonal, and motoric to determine problem areas of the patient's posttrauma state. Problem areas were then related to possible employment changes and outcomes.

Subjects

Four patients were selected who had received comprehensive neuropsychological evaluations. Only patients who had a prior work history of at least two years pretrauma were included in the study. Patients were selected who were at least two years posttrauma since it seemed reasonable to expect employment would be obtained by that time (Oddy, 1982). Only closed-head injured patients were selected to maximize group homogeneity. The cases were selected to illustrate the amifications of comprehensive vocational data for neuropsychology.

Results

Presented on your handouts (Appendix A) is an outline of the data from the four cases. First, pertinent background information is presented. Pretrauma and posttrauma jobs are listed along with corresponding DOT codes and Holland occupational codes (HOC). SDS data are presented along with examples of jobs matching the patients' HOC. ACL data are presented in terms of how many scales were more than one standard deviation from the mean and which

factors were predominately represented. A maximum of three factors are listed in descending order of significance. In a similar manner the PCL data are presented. Additionally, the number of items on which the significant other and patient overlapped is noted. Finally, neuropsychological data are presented. When called for, comments from the original neuropsychological report are included.

Discussion

Several issues appeared in developing this data base for neuropsychological vocational recommendations. The findings and comments are best represented by looking at each instrument in terms of its contribution to the data base. In general, inventories were sought that would highlight elements crucial to making significant vocational recommendations. Overall, the SDS was foremost in offering several markers around which further recommendations and vocational exploration could focus.

The SDS Holland-type information offers a focal point for individualized exploration of specific jobs. Jobs may be self-explored by the patient with subsequent dyadic exploration of options in counseling. An alternative to the SDS would be the Strong-Campbell Interest Inventory (Campbell & Hansen, 1981) which also provides a Holland code. However, the SCII does not ask for

a listing of career aspirations to check the congruency between aspirations and career interests. Nor is it possible to obtain differentiation or consistency measures from the SCII. Regardless of whether these last two measures represent decision-making ap itude it seems they shed light on how settled individuals are with their career. It seems these SDS indices may be generally depressed in a population with major career-interrupting trauma. However, in this study, while all four cases were below the fiftieth percentile on these measures (compared to the available high school student norms), it seems the two clients that showed adequate adjustment had relatively higher scores. Consequently, low scores may indicate those at risk for non-return to work and further point to individuals needing direct vocational intervention. Combining these data with the SDS Holland code and career aspiration information would show those who are clearly unsettled in their career plans Further interventions could explore whether the career incongruencies and confusion were an outgrowth of the career-interrupting trauma and, if so, what interventions could resolve or mitigate such disruption.

Whether the SDS indices of career confusion reflected a posttraumatic occurrence or not could be resolved by studying premorbid career adjustment. Much like reviewing a patient's

academic record to estimate premorbid intellectual functioning, the structured vocational interview provided a data base for analyzing premorbid vocational functioning. For example, some of the cases showed clear support for assuming adequate premorbid career adjustment. There were data showing consistent career areas with stable involvement over time. Hence, it would be assumed from that data alone that a return to work would be imminent. However, in support of the need for extended followups regarding vocational rehabilitation, two patient's with adequate premorbid career adjustment failed to return to work at four years posttrauma. The two cases of nonreturn had extreme, unexpected circumstances that may have been mitigated by longterm followup. In Case Two, the patient had numerous physical complaints that prevented him from engaging in his extremely physically tedious pretrauma job. In the other instance, Case Four had not returned to her night time computer terminal job (which had been held for her) because her car accident precipitated a phobia regarding driving at night. Intervention in such a case is clearly the domain of the psychologist and while such problems were noted in the final neuropsychological reports, they were not resolved. That the problems were not resolved may point to the limited emphasis neuropsychologists place on vocational rehabilitation.

Perhaps, at least, consultation with someone attuned to vocational problems would have pinpointed the career-interfering aspects of the phobia and physical complaints.

In the terms of the behavioral and emotional variables that were being explored to indicate problem areas for work adjustment, the data proved to be unweildy. Only in a very gross sense might the PCL have shown some problems. For example, Case Two showed mostly somatic complaints which was his main work problem area. However, the phobia in Case Four was missed by the PCL. The PCL hit mainly psychological, behavioral, and somatic areas (8, 9, and 10 questions respectively out of 37 total). Consequently, attention, memory, interpersonal, and organizational problem areas were under emphasized. However, it may be that the PCL's brevity would lend itself to a perusal of critical items rather than as an overview of clustered problem areas. Oddy (1982) used the checklist in a critical item fashion which was sufficient for his neuropsychology patients who only marked about 7 items. In contrast, this group tended to mark many more items making analysis more difficult.

Problems associated with too many items or scales also plagued the utility of the ACL. The 37 scales were difficult to use in any individualized fashion and the factor analysis results posed

problems as well. Individual scale use was a problem because the scales did not indicate whether emotional lability, temper tantrums, irritability, etc. were apparent enough to interfere with work. Certainly the numerous scales relating to transactional analysis, creativity, etc. were pointless in terms of the purposes of this study. The factor analysis results were a problem since all patients tended to have problem areas on the first three factors. Statistically this finding would be expected since the first three factors accounted for most of the inventory's variance. Furthermore, by the time high and low behavioral frequencies were considered along with negative or positive factor loadings, it was nearly impossible to conclude what scales actually contributed to the factors and thus what behavior problems were really prominent. All in all, the PCL alone may at this time be the best assessment in terms of contributing knowledge about potential behavioral and somatic complaints that interfere with work. Perhaps adding items to the PCL based on one's own needs would best earmark potential problem areas. Furthermore, since a "relative" version is available, the PCL is readily administered to significant others. Using a critical item technique on the PCL and making comparisons to the PCL Relative version is possible since the measure is relatively brief and has a "present--not present" format.

Comparing DOT codes across jobs seems to be a tactic that would be worth exploring in future research. However, for the practical purposes of vocational rehabilitation, the procedure seems redundant and unnecessary. The procedure was intended to indicate intrajob changes and highlight those changes in terms of neuropsychological markers. For example, it was assumed that major motor problems might influence a job emphasising Things worker traits. Therefore, a person might switch to a job that had the same Data, People worker traits while carrying a less demanding Things involvement. Discriminate analysis or regression procedures with large populations are needed to enlighten such conjecture. In terms of rehabilitation, such procedures might tip off a counselor to explore with the patient possible job shifts that would as near as possible include the same worker trait demands as a previous job.

Finally, the difficulties encountered in locating patients many years posttrauma highlights a need for early vocational data collection and consistent followup procedures. Data collection can be undertaken soon after release from the hospital and perhaps concurrent with collecting neuropsychological data. Particularly the SDS and structured vocational interview could be completed at that time. By reviewing the SDS indices and assessing premorbid

career adjustment, those at risk for nonreturn to work could be identified. Those potentially at risk could be followed frequently or be referred for further vocational counseling. At a later date, if vocational adjustment problems appeared with those thought initially to be not at risk, the PCL could be administered along with a brief structured vocational interview to fill in interim vocational details (such a training programs or jobs tried to date). The PCL and interim interview data along with the earlier collected SDS and interview data could then serve as a lead for directing vocational exploration and intervention.

References

Anchor, K. N., Peacock, C., Sieveking, N., & Pressley, B. (1979). Work behavior sampling in vocational assessment: Applications for a neuropsychological methodology. Clinical Neuropsychology, 1, 51-53.

Ben-Yishay, Y., Gerstman, L., Diller, L.,& Haas, A. (1970). Prediction of rehabilitation outcomes from psychometric parameters in left hemiplegics. Journal of Consulting and Clinical Psychology, 34, 436-441.

Blyth, B. (1981). The outcome of severe head injuries. New Zealand Medical Journal, 93, 267-269.

Campbell, D. P., & Hansen, J. C. (1981). Manual for the SVIB-SCII. Palo Alto, CA: Consulting Psychologists.

Filskov, S. B., & Boll, T. J. (1981). Handbook of clinical neuropsychology. New York: Wiley.

Golden, C. (1978). Diagnosis and rehabilitation in clinical neuropsychology. Springfield, IL: Thomas.

Gottfredson, G. D., Holland, J. L., & Ogawa, D. K. (1982). Dictionary of Holland occupational codes. Palo Alto, CA: Consulting Psychologists.

Gough, H. G. (1980). The Adjective Checklist. Palo Alto, CA: Consulting Psychologists.

Heaton, R. K., & Pendleton, M. G. (1981). Use of neuropsychological

tests to predict adult patients' everyday functioning. Journal of Consulting and Clinical Psychology, 49, 807-821.

Holland, J. L. (1977). The Self-Directed Search. Palo Alto, CA: Consulting Psychologists.

Holland, J. L. (1979). The Self-Directed Search: Professional manual. Palo Alto, CA: Consulting Psychologists.

Holland, J. L., Gottfredson, G. D., & Nafziger, D. H. (1975). Testing the validity of some theoretical signs of vocational decision-making ability. Journal of Counseling Psychology, 22, 411-422.

McCarron, L. T., & Ludlow, G. C. (1981). Sensori-neural deafness and neuromuscular dysfunctions. Journal of Rehabilitation, 47, 59-62.

Najenson, T., Groswasser, Z., Mendelson, L., & Hackett, P. (1980). Rehabilitation outcome of brain damaged patients after severe head injury. International Rehabilitation Medicine, 2, 17-22.

Oddy, M. (1982, October). Vocational outcomes following head trauma (and directions for the future). Paper presented at the Fourth New Beginning Conference, Toronto.

Oddy, M., & Humphrey, M. (1980). Social recovery during the year following severe head injury. Journal of Neurology, Neurosurgery, and Psychiatry, 43, 798-802.

Reitan, R. (1966). Diagnostic inferences of brain lesions based on

psychological test results. Canadian Psychologist, 7a, 368-383.

Roberts, A. H. (1979). Severe accidental head injury: An assessment of long term prognosis. London: McMillan.

Rowell, W. J. (1968). Some relationships among fathers' perceptions of sons' problem-solving ability; fathers' teaching methods; and fathers' descriptions of self and son. (Doctoral dissertation, University of North Carolina, 1967). Dissertation abstracts, 28, 4763B.

Scarr, S. (1966). The Adjective Checklist as a personality assessment technique with children: Validity of the scales. Journal of Consulting Psychology, 30, 122-128.

U. S. Department of Labor. (1977). The dictionary of occupational titles (4th ed.). Washington, DC: U. S. Government Printing Office.

Appendix A

Case One

37 year old, married, female; interviewed 5½ years posttrauma car accident; comatose one month; hospitalized three months high school education; business courses completed at local college

Pretrauma job: Secretary (DOT: 201.362-030; HOC: CSE)

Posttrauma job: Title Clerk, Automobile (DOT: 203.582-066; HOC: SEC)

SDS: CSE (clerical, social enterprising): approximately 200 possible jobs including systems accountant, title examiner, title supervisor, account analyst, administrative clerk, bookkeeper II, claims clerk I, auto bill contract clerk, account clerk, insurance clerk, legal secretary, clerk supervisor, many general clerk jobs.

Career aspirations: keypunch operator, clerk-typist, phone operator, bookkeeper

Differentiation: 26; Consistency: 2

ACL--Patient: 7 scales; is sociable, is assertive, is potent

ACL--Other: 29 scales; is sociable, is potent, is assertive; agreed with 5 of patient's problems--somatic mainly

Neuropsychological testing. Two months post: Wechsler Adult Intelligence Scale (WAIS: FS = 79, V = 84, P = 74; Rey Memory Test, Memory for Designs, and portions of the Wechsler Memory Scale (WMS) (intact long-term processes, accurate memory for up to two minutes, problems transferring to long-term storage); Reitan-Indiana Aphasia Screening (no problems noted). Five months post: WAIS (FS = 102, V = 100, P = 103); WMS (MQ = 87); MMPI (2-8 high-point pair). Seven months post: WMS (MQ = 106); MMPI (2-8 high-point pair).

Case Two

24 year old, single, male; interviewed 4 years posttrauma motorcycle accident; comatose 21 days; hospitalized 35 days 10th grade education; GED completed at age 17

Pretrauma job: Harvest Worker, Vegetable (DOT: 402.687-014; HOC: RCE)

Posttrauma job: Gardener (DOT: 301.687-018; HOC: RES)

SDS: SRA (social, realistic, artistic): this code does not match any current U. S. jobs. SRE (social, realistic, enterprising): approximately 50 possible jobs including athletic trainer, various supervisors in industry, community dietician, border guard, narcotics/vice detective. RSA (realistic, social, artistic): no U. S. jobs.

RCE (realistic, social, enterprising): approximately 500 possible jobs including various jobs of farmwork, auto repair, electrical repair/service, cook; many general labor, operator, assembly, and supervisor jobs.

Career aspirations: special education teacher, coach

Differentiation: 10; Consistency: 1

ACL--Patient: 3 scales

ACL--Other: 11 scales; lacks sociability, is assertive, lacks potency; agreed with 0 of patient's scales

PCL--Patient: 10 problems; behavioral, psychological, organizational

PCL--Other: 12 problems; psychological, behavioral; agreed with 5 of patient's problems--psychological mainly

Neuropsychological testing. Two months post: WAIS (V only = 83); WMS (MQ = 63); Aphasia (no language-related problems; left hemiparesis). Seven months post: WAIS (FS = 79, V = 83, P = 77); WMS (MQ = 79); Aphasia (dysnomia, dysarthria); Tactual Performance Test (dominant, right = 12' 54", nondom = 4' discontinued with 4 blocks in, memory = 6, location = 0); Trails A (50" no errors) and B (165" no errors). Fourteen months post: WMS (MQ = 73); Aphasia (no language errors; left hemiparesis still evident).

Case Three

58 year old, married, male; interviewed 4 years postrauma motorcycle accident; comatose about 1 hour; hospitalized 28 days

GED

Pretrauma job: Farmer, Field Crop (DOT: 404.161-010; HOC: REI)

Posttrauma jobs: Farmer, Field Crop (DOT: 404.161-010; HOC: REI); Sales Agent, Insurance (DOT: 250.257-010; HOC: ESR)

SDS: ERS (enterprising, realistic, social): approximately 300 possible jobs including brokers floor representative, dealer accounts credit officer, game breeding farm manager, harvest contractor, chief inspector, load dispatcher, sales manager, and numerous supervisor jobs. RES (realistic, enterprising, social): approximately 1700 jobs including various jobs of supervisors in industry, electricians, inspectors, mechanics, tenders/operators, helpers, and laborers.

Career aspirations: combine operator, service career, truck driver

Differentiation: 16; Consistency: 2

ACL--Patient: 14 scales; lacks potency, lacks sociability, lacks assertiveness

ACL--Other: 13 scales; lacks potency, lacks assertiveness; agreed with 7 of patient's scales

PCL--Patient: 21 problems; somatic, psychological, organizational

PCL--Other: 19 problems; somatic, psychological, interpersonal; agreed with 14 of patient's problems--somatic/psychological mainly

Neuropsychological testing. Three months post: WAIS (FS = 103, V = 106, P = 99); WMS (MQ = 89.5); Categories (101 errors); Seashore Rhythym (SSR = 7 errors); Speech Sounds Perception (SSP = 26 errors); Trails A (38" no errors) and B (65" no errors); Tapping (dom, R = 41.7, nondom = 36.2); MMPI (1,2/2,1 tied high-point pair). Five months post: WMS (MQ = 114); Categories (26 errors); Sensory Perceptual Exam (SPE = one right finger agnosia; three errors each hand on finger-tip number writing; visual, auditory, and tactile processes reported as within normal limits); TPT (dom,R = 5' 56", L = 3' 52", B = 2' 21"; memory = 8, location = 7); Tapping (dom,R = 43.6, nondom = 37.6).

Case Four

34 year old, widowed, female; interviewed 3½ years post
car accident; comatose about 1 day; hospitalized 20 days
high school education; 98 hours toward bachelor's degree

Pretrauma jobs: Terminal Operator (DOT: 203.582-054; HOC: CSE); Electronics Assembler (DOT: 726.684-018; HOC: CRS)

Posttrauma job: None

SDS: CSA (conventional, social, artistic): no U. S. jobs. SCA (social, conventional, artistic): hand sign painter.

Career aspirations: nurse, computer operator, typist

Differentiation: 20; Consistency: 2

ACL--Patient: 16 scales; lacks sociability, is potent

ACL--Other: 9 scales; lacks sociability, lacks potency; agreed with 1 of patient's scales

PCL--Patient: 8 problems; psychological, somatic, memory

PCL--Other: 5 problems; somatic; agreed with 3 of patient's problems

Neuropsychological testing. Three months post: WAIS: (FS = 94, V = 91, P = 97.5); WMS (MQ = 99); Categories (87 errors); SSR (5 errors); SSP (5 errors); Trails A (31" no errors) and B (50" no errors)